MERCY FAMILY MEDICINE OF CORALVILLE

HEALTH HISTORY FORM

PATIENT NAME
DATE OF BIRTH
CURRENT DATE
VISIT DATE

MAIN REASON FOR VISIT: _____
_____
OTHER CONCERNS: _____
Are your immunizations up to date? ☐ No ☐ Yes

ALLERGY LIST

☐ None

Allergic to:	Reaction:	Allergic to:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATION LIST

(Bring all bottles)

Prescriptions	Dose	How often?	Prescriptions	Dose	How often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	**Herbals, OTC Drugs, Supplements, etc...**	**Dose**	**How Often?**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PROVIDER LIST

(Other physicians providing care)

Name	Specialty/Type of Care
_____	_____
_____	_____
_____	_____

CURRENT CONDITIONS LIST

(Chronic, Acute, or Recurrent)

Condition	Onset Date	Managing Provider (if other)	Last Seen Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYMPTOMS

(✓ all in the past 2 weeks)

☐ No Symptoms

Blood/Lymphatic/Skin
☐ Easy bleeding
☐ Easy bruising
☐ Swollen glands
☐ Unexplained lump
☐ Change in mole/skin spot
☐ New mole/skin spot
☐ Rash

Ears/Eyes/Nose/Throat
☐ Ear pain
☐ Hearing problems
☐ Vision problems
☐ Hay fever/allergies
☐ Stuffy nose
☐ Throat pain
☐ Trouble swallowing

Genitourinary
☐ Abnormal vaginal bleeding
☐ Sexual function concern
☐ Penis/Vagina Discharge
☐ Leaking urine
☐ Urinating a lot at night
☐ Painful urination
☐ Blood in urine

Gastrointestinal
☐ Blood in bowel movement
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea
☐ Stomach pain

General
☐ Feeling tired
☐ Feeling weak
☐ Fever
☐ Sweats
☐ Weight loss/gain

Neurological
☐ Dizzy
☐ Fainting
☐ Headaches
☐ Memory loss
☐Recent falls

Endocrinology
☐ Feeling cold
☐ Feeling heat
☐ Increased appetite
☐ Increased thirst

Psychiatric
☐ Anxiety
☐ Feeling down
☐ Sleeping problems
☐ Stress

Cardiovascular
☐ Chest pain/pressure
☐ Heart racing
☐ Swollen legs

Respiratory
☐ Cough
☐ Shortness of breath
☐ Wheeze

Breast
☐ Breast lump
☐ Lump in armpit
☐ Nipple leaking

Musculoskeletal
☐ Joint Pain
☐ Muscle Pain
☐ Recent back pain

WOMEN'S HISTORY

of pregnancies: ____ # of deliveries: ____ Age at start of periods: ____ 1st day of Last Menstrual Period:
# of miscarriages: ____ # of abortions: ____ Age at end of periods: ____ _____

Name:	DOB:	Date:

STUDY/TEST LIST

Type	Date	Normal	Abnormal Find	Type	Date	Normal	Abnormal Find
Colonoscopy	_____	☐	_____	HgA1c	_____	☐	_____
DEXA Scan	_____	☐	_____	Blood Sugar	_____	☐	_____
EKG	_____	☐	_____	INR	_____	☐	_____
Mammogram	_____	☐	_____	Lipids	_____	☐	_____
Pap Smear	_____	☐	_____	PSA	_____	☐	_____

PRIOR HOSPITAL VISIT/SURGICAL/PROCEDURE HISTORY

Type	Location/Physician	Date	Type	Location/Physician	Date
Appendectomy	_____		Splenectomy	_____	
Breast Surgery	_____		Tonsillectomy	_____	
Gallbladder	_____		_____	_____	
Hysterectomy	_____		_____	_____	
Joint Surgery	_____		_____	_____	

(✓ to indicate positive history) **MEDICAL/FAMILY HISTORY**

	Self	Father	Mother	Brothers	Sisters	Comments
Deceased, Age	XXXXXX	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____
COPD	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Eye Conditions	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____	_____
Sleep Apnea	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Thyroid Problem	_____	_____	_____	_____	_____	_____
Other Cancer	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

SOCIAL HISTORY

Tobacco	☐ No ☐ 2nd hand	☐ Current, type: _____	amt per day: ___	☐ Prior use, quit date:	_____
Alcohol	☐ No	☐ Daily, type: _____	amt per day: ___	☐ Prior use, quit date:	_____
Drugs	☐ No	☐ Daily, type: _____	amt per day: ___	☐ Prior use, quit date:	_____
Exercise	☐ No	☐ Regularly, type: _____	amt per wk: ___	Special or Prescribed Diet?	_____
Education	Current Grade: _____	Level completed: ☐ GED	☐ High School: _____	☐ College:	_____
Work	☐ Full-time ☐ Part-time	☐ Retired	Occupation:	_____	

	HOME				
Marital Status	☐ Divorced	☐ Married	☐ Single	☐ Widowed	☐ Other:
Living Arrangement	☐ Apartment	☐ Assisted Living	☐ House	☐ Nursing Home	☐ Other:
Living Situation	☐ Children	☐ Independent	☐ Parent(s)	☐ Significant Other	☐ Other:
Safety	☐ wear seatbelt	☐ home safety plan	**Abuse**	☐ physically	☐ verbally
Advance Directives	☐ Living Will	☐ Power of Attorney	Do you want advance directive information?		☐No ☐Yes